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ABSTRACT

This paper on the importance of intercultural communication focuses on the health care needs of people in the United States and other countries and on the communication problems the diverse cultures of these countries present for health care professionals. The paper first discusses the cultural orientations of Mexican immigrants in the United States, the peoples of Nepal, and the Japanese, and the health problems of each of these populations. It then explores the need for intercultural communication training within health care curricula to enable professionals to work effectively in these cultures. The paper next presents an outline for an intercultural communication course designed for health care majors at California State University (Northridge) that (1) explores different sociocultural factors, role theory, attitudes and values, language, and verbal and nonverbal communication and (2) provides field experience in an intercultural health setting. Appendixes include a class syllabus, an intercultural communication bibliography, and required courses for health education degrees. (HTH)

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INTERCULTURAL HEALTH COMMUNICATION IN THREE DIFFERENT SETTINGS

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ABSTRACT

Intercultural Health
Communication in Three Different Settings

The study of intercultural communication is an important aspect of many Speech Communication programs at colleges nationally. The large number of Latinos in the United States and the heterogenous composition of many foreign countries, intensify the importance of intercultural communication awareness and training. There is a special need for health service workers to understand various cultural orientations and to communicate effectively within the cultures in order to develop successful health care delivery systems, both in the United States and abroad.

In this paper, the authors discuss three settings which have interpersonal and intercultural communication problems, describe the resultant need for professional health science training in cultural communication, and describe an intercultural communication course currently taught for Health Science students at California State University, Northridge, U.S.A.

I. Introduction

The study of intercultural communication is a vital part of many Speech Communication programs throughout the country. Communication educators generally agree that students need the ability to apply human communication principles to intercultural communication settings. The high influx of immigrants from various cultural backgrounds, in addition to the large existing United States minority population, intensify the importance of intercultural communication awareness and training. Both domestically and internationally, students may encounter situations where the ability to analyze the process of human communication in intercultural situations and to utilize communication skills is critical. Generally, intercultural communication courses provide the environment in which students discuss variables in the communication situation and evaluate their impact on intercultural communication.

There is a special need for health service workers to have an understanding of health orientations of various cultures. In this paper the authors discuss the health needs of people in three different settings: Nepal, Japan, and the Latino communities within the United States.

Focus will be on the health needs of people in these three settings and problems associated with providing health services to them. In addition, the need for the development of special skills in interpersonal and intercultural communication and the development and implementation of a course in Intercultural Communication for Health Educators will be discussed.

II. Interpersonal and Intercultural Problems in Health Care Delivery in Three Different Cultural Settings

Overview

The health care professional's need for interpersonal and intercultural training is illustrated through the examination of one domestic and two foreign

health care environments. In the United States, with the high influx of Mexican immigrants arriving daily, one culture becomes superimposed upon another. Cultural barriers among the Mexican immigrants, the Mexican-Americans (persons of Mexican cultural background who are born in the United States) and Anglos present communication problems in many areas of interpersonal relations and especially in providing health care. Language differences intensify the problem. The traditional Mexican immigrant contrasted with the assimilated American born Mexican-American versus the modern anglo health care message provide a good justification for interpersonal and intercultural skills training for health care workers.

In addition to this domestic situation, Japan provides a further example of intercultural communication problems in health care. The contrasts between the traditionally oriented society versus the new post World War II industralist population, cause many communication problems in Japan. The pre-war poverty and the accompanying problems of starvation and illness were typical of under-developed nations around the world. Presently this country, although highly sophisticated industrially, has a heterogenous -- rural vs. urban and traditional versus modern population. One health message will not suffice here, and thus necessitates training for the health practitioner in inperpersonal and intercultural communicatio

In Nepal, the many languages and subcultures present the pressing intercultural communication problem of how to provide health care to such a divergent group. The problem of having major health facilities in the cities and major segments of the population in the rural areas necessitates a health care challenge.

The traditional, religious orientation, many subcultures, and a variety of languages all work together to create interpersonal and intercultural concerns for the health care professional in Nepal.

Although the problems facing the health worker servicing Mexican-Americans, Nepalese, and Japanese are quite diverse, the need for interpersonal and inter-

cultural skills training is obvious. The following sections elaborated on these three examples.

Providing Health Service to Mexicans and Mexican Americans in the United States

Researchers in the area of health care delivery have documented that poor Americans generally have a different orientation toward health beliefs and actions. In many cases Latinos, living in America, fall into the category of the poor, and their cultural orientation toward health care intensifies the interpersonal and intercultural communication problems involved in health care delivery.

Hooker reported that there were differences in the basic assumption about the self and health care among middle class Americans, poor Americans, and Mexican-Americans. While middle class Americans may view the enate character of human nature as "neutral," poor Americans may view it as "neutral," but add, ". . .illness may be regarded as a cross to bear," while Mexican-Americans view human nature as "neutral or evil," and may view illness as ". . .castigo or a trial to be suffered (9:23).

Poor people may find health care difficult to obtain, but within the Latino community in the United States, culture, family structure, language, and general attitudes toward illness work together to create additional communication problems in the dissemination and diffusion of American health care ideas into the Latino life style.

While warning against generalizations, Murillo, creates a picture of the Mexican-American which may also relate to the picture of the Mexican immigrant They may tend to accept life as it comes, because they view only so much available and, therefore, perceive striving for more as futile (14:8). This concept of "limited good" may account in part for many Mexican-Americans acceptance of illness that occurs, and may lead to hesitance in seeking formal health care.

In addition to the general view of life, the family structure may affect the success of dissemination and acceptance of health care within the Mexican-American communities. The Mexican-American family, according to Murillo, provides, "emotional and material security," and this may account, in part, for the Chicanos hesitance to seek professional medical and emotional assistance (14:10).

The health care worker's understanding of the life view and family strength of the Mexican-American may not eliminate the communication problems in providing health care in this intercultural situation. Many authors have cited the concept of illness in the Mexican-American's beliefs as "castigo" or illness being caused by disobeying God's commandments (3:93). Illness may be perceived as resulting from ". . .suffering imposed by God, since suffering is man's lot" (3:93). The concept of the "mal ojo" or "evil eye" as the magical origin of many maladies and especially of children's illnesses is an example of the mystical orientation of the traditional Mexican view of illness. This mystical view, discussed in the literature (see e.g. 18:67) intensifies the intercultural problems in providing health care to Mexican-Americans.

If a family believes that a person's lot in life may be to suffer, that people may be inherently evil, that the family is able to care for its own, or that a healer (curandero) will help, the Anglo concept of formal professional care may not be seen as necessary. Alcoholism amongst the Chicano serves as an example of this phenomenon. The whole concept of machismo as a way of life may deter a family from encouraging an alcoholic Chicano to seek professional assistance (12:35).

This condition of alcoholism may be viewed as moral weakness relating to the concept of castigo. In fact the cultural inappropriateness of health service has been cited as the greatest barrier to utilization of alcoholism control amongst Chicanos (1).

McKinlay (11) suggested that one's symptom recognition and treatment may be strongly influenced by one's cultural orientation. The cultural orientation, family structure, and mystical view of illness may strongly influence the Mexican-American's view on illness and health care. The Mexican immigrant may have a greater problem adjusting to the Anglo system of health care than the Mexican immigrant. The problems become even more magnified when language differences are added. While many Mexican-Americans speak English, the Mexican immigrant usually does not. Thus, language may be an additional barrier. Many of the community problems that the health care worker encounters with the Mexican-American in the United States are also present in foreign environments. Two different foreign environments are discussed in the next two sections.

Providing Health Service in Nepal

Nepal is a tradition-oriented society with wide-spread religious beliefs and age-old traditions and superstitions. It is the only true Hindu monarch left in the world today. This tiny Hindu kingdom is about half the size of California yet boasts a population of 13 to 14 million. Ninety-six percent of the population of Nepal live in rural areas, with the vast majority in a low socio-economic class. Nepal is essentially an agrarian society with over 90% of its economy based on agricultural products (4:22).

Most of the country's ills can be attributed to: a) overpopulation (with a 2% annual growth rate): b) lack of proper sewage and garbage disposal; c) highly contaminated drinking water; and d) poor personal and environmental health practices.

The most prevelant disease resulting from these conditions include cholera, amebic dysentery, typhoid, infectious hepatitis, malaria and leprosy.

In addition, there is an extremely high infant mortality in Nepal. Because of the difficulty in gathering data, accurate statistics are hard to come by. It has been estimated, however, that from 40% to 50% of all children born die before they are one year of age. Over 90% of infant deaths are due to dehydration from excessive diarrhea.

Because of the high infant mortality and high mortality rates associated with numerous communicable diseases prevalent in Nepal, life expectancy is 28 to 35 years of age (depending on one's data source) (5:25).

Delivery of Health Services

In Nepal, health care facilities are primarily located in major cities, such as Kathmandu, Birgunj, Pokhara, Nepalgunj, Paton and Bhaktapur (8). This presents a major problem in the delivery of health services in that less than 10% of the population of Nepal live in these cities.

Two relatively recent campaigns were developed to help remedy this problem. One, named the "Back-to-the-Village Campaign," was initiated in the early 1970s (4:25). In this program doctors and other health workers were expected to spend one year of service in a remote area. While the program offered some assistance to the outlying area, it was a hit-and-miss approach that did not prove to be too successful. A primary problem was that the health workers sent to remote areas were not accepted by the villagers. There was a tremendous communication and credibility gap between those providing health services and those receiving these services.

The second campaign was called the "Integrated Health Service project" (2). It was piloted in 1974-75 and is still being implemented today. In this program, villagers are trained to be auxilliary health workers (similar to the bare-foot doctors in China). These trained local people, accepted by the community, provide preventive as well as minimal curative services.

This program has made some headway in reducing the communication and credibility gap between those providing health services and those receiving these services. However some basic communication problems still exist. Some of these problems are enumerated below:

1. While the germ theory and infectious disease cycle are well accepted

by the technological, scientific and health professional communities in Nepal, the majority of Nepalis believe that individual ills are generally attributed to punishment by the Gods for evil acts committed in one's present or previous existence (4).

2. In addition, Nepal is an ethnically complex country. There are over 17 different languages with a number of local dialects (22). It is not uncommon for two villagers separated by a single mountain range or river to have separate languages. Indeed, the twenty-five major zones of Nepal have a variety of sub-cultures, each with their own values, traditions and folklore.

3. A number of religious beliefs and superstitions permeate the society and are in direct conflict with health messages that are delivered to the masses.

4. Most health communications are further hindered by lack of radio and television and a very low literacy rate. Less than 15% of the population is literate. Thus, health communications, to be effective, must generally be personal face to face and oral (4).

5. Media that is developed (posters and films) are often too generic to be relevant to the diversified subcultures in Nepal.

Another factor that must be taken into account when considering the delivery of health services in Nepal is the topography of the country. Eighty-five percent of Nepal consists of mountains that range from 14,000 feet to 29,000 feet and hills with deep cut valleys. The remaining 15 percent of the country is Flat Plains (the Terai) that swelters in unbearable heat during the summer months or is innundated by floods from torrential rains and overflowing rivers. This coupled with the lack of good roads and railways makes it extremely difficult to reach many rural villages except by foottrails.

Providing Health Service in Japan

Japan is the only major non-Western country that has become a thoroughly industrialized and modernized society. Today in economic size it stands third in the world, ahead of the once great powers of Western Europe and ranking only behind the two great continental superpowers, the United States and the Soviet Union.

The population in Japan was 111.9 million in 1975, when it was the sixth largest country in the world, and its population growth was 1.35% in that year. This highly populated country has a population density of 300/km^2 (135/km^2 in rural areas). In 1975, seventy-five percent of the toal population lived in city areas. The distribution of the population by industry type in 1975 was: 13.9% in primary, 34.1 in secondary, and 51.7% in tertiary industries. In 1955 the figues were:41.0, 23.5 and 35.5% respectively, demonstrating the major influence of industrialization.

Changing Concepts of Health and the Delivery of Health Services

The main health problems in the Meiji era (1868-1912) were acute communicable disease such as sholera epidemics, typhoid fever, bacillary dysentry, trachoma and venereal disease. Lack of environmental sanitation was a major problem and contributed to the high incidence of communicable disease. Later, as the industrialization of Japan developed and the movement of people from rural to urban area occurred, tuberculosis and maternal and child health also became major health problems.

Public administration in the country was strongly centralized from the Meiji era until the end of World War II. Therefore, health programs for the control of various communicable diseases were planned by a national agency and carried out through the administrative channels of the police. Local vaccination programs, such as those for typhoid fever and smallpox were carrried out directly by the police office or by town or village offices under the direction of the police (6).

At the end of the war there was a change in the political structure from militarism and autocracy to a democracy, and a period of rapid economic development and industrialization ensued.

Due to the higher standard of living resulting from significant economical development and better health practices, the health of Japanese people has greatly improved through the years. Many health indices, such as infant mortality, death rates of new born children, prenatal death rates and death rates from all causes have shown rapid decline in the last 30 years. During this period communicable diseases have been greatly controlled. However, there has been an increase in the prevalence of chronic diseases such as heart and cancer and circulatory diseases especially in the older age groups.

The diseases that are most prevelant in the country today include: cerebrovascular disease, malignant neoplasma and heart disease. Other major health problems during the past twenty years include health needs of mothers and children, mental illness, obesity, health needs of aged and environmental health problems, including accidents. These problems are quite similar to those in industrialized Western countries.

The Diversity within the Changing Japanese Culure and the Problems of Delivering Health Services

Successes of past health measures, together with socio-economic changes, have resulted in changing the nature of health problems themselves. Today the major health problems in Japan are as follows:

1. The main causes of death have changed from infectious disease to long-term illness. The shift in control and treatment of communicable disease to chronic and degerative disease has led to the need for new voluntary programs requiring community support and individual motivation. The chronically

ill do not present the same threat to the health of the general public as do individuals with communicable disease. However, there is a great public economic drain in the attempt to treat and cure individuals with degenerative or chronic disease. Health is both an individual and public concern. Thus, health personnel today must utilize information relating to social organization, work environments, community action, individual behavior and communication.

2. The very rapid aging of the population is another problem in Japan. It is a common issue in advanced countries. However, in Japan this problem has become more complicated since changes in family systems and related social changes have proceeded simultaneously (16).

Traditionally, the Japanese family has been categorized as a "large-family" type. The first make child lived with the parents after marriage and took responsibilities for caring for the parents (23). After World War II, emphasis on individuality and democracy within the family replaced the feudalistic concept of the family system. Too, the Japanese people have changed their views relative to caring for the elderly. This has created misunderstanding and confrontation between generations (10:27).

3. In Japanese society, the hierarchical kin group of the past are gradually changing so that social class is related to a person's occupation, and the chances of staying alive and remaining healthy are not distributed equally among persons in different economic classes. Members of the lower class have higher proportions of both physical and mental illnesses than to the middle and upper classes and receive generally inferior treatment from medical personnel (24).

Such problems must be dealt with through a program of health education that emphasizes good health as a basic birthright of every individual and is designed to eliminate the effects of social class position on health care and services.

4. In the past, the basic unit of the Japanese social life was the family. Within the family the females were in an inferior social position. In recent years, there has been a change in the patterns of authority within the family with adult females having some part in making family decisions (15). However, in several rural areas, women who married into farm households used to refrain from consulting doctors even when they were seriously ill. This was because of their over-consideration for other family members. Wakatsuki coined a phrase, "the bride's effect" to refer the particularly low consultation rate among brides in farm households (26).

5. Some people who suffer from tuberculosis, leprosy or mental illness have kept themselves hidden instead of seeking medical attention. Their prejudice toward such illness was due to misunderstanding of the cause of the disease as hereditary and therefore creating shame upon the family. This is an example of the "shame culture" existing in Japan (7).

6. Traditionally, religious teachings and practices were important in helping the Japanese people cope with many practical daily problems and life stresses. The religions of Shinto and Buddhism were the principal faith, but since World War II these religious systems have lost much of their importance.

Cultural conflicts, however, continue to exist between the traditional and newer Japanese social and economic systems. In 1966 ("the fire-horse--hinoe-uma year") for instance, the Japanese birth rate was 25% lower than the previous national average birth rate. Many couples avoided childbearing due to a superstition that female babies born in that year would be destined to unhappy lives.

The rapid spread of family planning practices by sex education ironically greatly contributed to those superstitions. It is indicated that the worker in health may actually be wielding a two-edged sword if they apply all of the present health knowledge without consideration of the effect of cultural orientations on the health care situation.

Health Education in Japan

Prior to World War II, health education activities focused primarily on the dissemination of health information. There was no real attempt to utilize principles of motivation to modify health behavior (13). At the end of World War II, health education emerged in three phases. Before the War health education meant the dissemination of health information through lectures, film and posters. The focus was on one-way communication. Educational opportunities such as health consultation, home visits and sanitary inspections were not considered as health education activities. The second phase was a shift from talking to people to working with people. Thus, two-way communication emerged. The third phase was the introduction of social sciences into health education, with stress on behavior modification.

As a result of these changes, altering health behavior was seen as an objective of health education and the need for interpersonal and intercultural communication in health education has been gradually recognized.

III. The Health Practitioners Need for Special Skills in Intercultural Communication and the Development of a Special Course

Our experiences in Nepal and in Japan and with Latinos living in the United States, have clearly pointed out that the health educator or any health worker who is trying to modify the health behavior of people with different values, beliefs and perceptions must have special skills in interpersonal and intercultural communications. To be effective, health messages must be relevant to the needs, values and beliefs of all individuals in the community. As Hooker pointed out: "The interrelationships of health beliefs and health actions and the values held by members of the culture need to be understood if changes in those beliefs and actions and the values held by members of the culture need to be understood if changes in those beliefs and actions are to be accomplished (9:34)."

While many of the courses offered as a part of the undergraduate preparation of health science majors include various aspects of interpersonal and intercultural communications, these courses do not provide specific training in the necessary communication skills required of those working in culturally divergent settings. Examples of health science majors' course offerings at California State University, Northridge (CSUN) in the United States and at Utsunomiya University in Japan may be found in Appendices 3, 4, and 5. Students in these courses have expressed a need for interpersonal and intercultural communication skills training above and beyond the information provided in the health science curriculum.

Because of the expressed intercultural problems in both domestic and foreign sectors examplified above and the student and professional health educators' interest in the area, a special course entitled, Intercultural Communication in Health Science was developed as a requirement for the health science major at CSUN.

The major course objectives are to increase the students' understanding and application of interpersonal and intercultural communication skills as they relate to the health care situation (see Appendix 1 for detailed list of course objectives).

In order to fulfill the objectives students participate in a number of activities, read several texts (17, 19) and articles, design and execute a project and take exams. The course is divided into the following sections:

1. Introduction to the Communication Process with Definitions and Theories of Intercultural Communication

   The students begin by examining what happens in the communication process and what added results occur when communication involves people of different backgrounds. We look at culture, in general, and focus more specifically on concepts of health and illness in cultures.

Role playing and case studies such as Bafá Bafá and Starpower games are useful devices for helping students understand the relationship of these concepts (20, 21).

2. Socio-Cultural Factors

Students examine their own cultural backgrounds, try to recognize ethnocentism in themselves, and understand how it can drastically affect a health worker's effectiveness. The interrelationship between perception and its effects on stereotypes and prejudice are also discussed.

3. Roles, Culture and Intercultural Communication

Role theory provides needed background for health workers who must understand the family roles of a cultural group with whom they are working as well as the role of the doctor, other health authorities, the medicine man and all who participate in any given society.

4. Beliefs, Attitudes and Values

The concepts of health and illness are closely linked to a society's values and it is therefore essential for students to understand how values, attitudes and beliefs affect the success of health programs, and also how different beliefs, attitudes and values may be diffused by one culture from another.

5. Language and Verbal Symbols

Language itself, as an embodiment of a culture, affects an intercultural communication situation. Students study how one's attitudes toward the language of a person may distort their abilities to be effective health care workers.

6. Nonverbal Communication

Nonverbal communication may be more accurate in communicating emotions than verbal communication. A health worker must interpret accurately differences in time, place, dress, posture, facial expression, touch behavior, vocal cues, etc.

7. Field Experience

The purpose of the field experience is to participate actively in an intercultural health setting and to have students report in a journalistic diary about their observations and feelings in this situation.

8. Projects

In addition to the class work, students are required to complete a project. The purpose of the project is to analyze and evaluate intercultural communication in a health setting. The project can be a survey type, an in-depth case study or a participant-observation study. Each project attempts to relate theoretical constructs to a practical situation. The following are sample topics of term papers written by students in this class: Chicano alcoholism, Mexican-American's diet and heart disease, Birth control consulting and minority women.

A class, such as the one discussed here, specially designed for health service majors, may provide a valuable learning experience because the instructor can focus attention on the kinds of situations the health worker may encounter domestically and abroad.

IV. Summary and Future Directions

In order to modify the health behavior of people with different values, beliefs and perceptions, health professionals must have special skills in intercultural and interpersonal communications. This has been illustrated in the paper through the discussion of the health needs and communication problems in three different settings. While course offerings in Health Science cover some aspects of intercultural and interpersonal communication, there is a need for a specific course which provides necessary intercultural and interpersonal communication skills. Such a course was also described in this paper.

What is now needed is an on-going in-service training program in intercultural communication for those already in the field. In addition, program administrators must be educated as to the value of such skills training. Finally, continuing research that identifies health values, beliefs and perceptions is needed along with research that assess the effectiveness of training programs. A research team consisting of communication and Health Science professionals at California State University, Northridge, is currently developing such research and training programs.

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Intercultural Health
Communication in Three Different Settings

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APPENDIX 1

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INTERCULTURAL COMMUNICATION SPC 356
INTERCULTURAL HEALTH COMMUNICATION SPC 356H

Textbooks: Rich, A.L. Interracial communication. New York: Harper and Row, 1974.

Samovar, L.A. & Porter, R.E. (eds.) Intercultural communication: A reader. Belmont: Wadsworth Publishing Company, 1976.

Course Description: This course examines main concepts and principles of communication applied to public health and intercultural communication situations. It deals with communication problems we encounter in various settings. The course will explore communication variables such as verbal and nonverbal language, roles, and perception, in addition to many other factors such as ethnocentrism and prejudice, which interact and affect the communication process.

Approach: The course will include lecture/discussion sessions, analysis of actual and hypothetical cross-cultural communication situations, intercultural simulation experiences, small group activities, films, guest speakers, and field activities. Active participation is a necessary part of this class. Relevant reading assignments should be done before class.

Evaluation and grading: Attendance & participation 10%; Midterm 25%; Field experience 10%; Final exam 25%; Group or Individual Term Project (includes oral and written presentation) 30%.

Ground Rules: Attendance will be considered in grading, along with class participation. The final grade will be reduced for excessive unexcused absences. Each student is encouraged to speak with the instructor in conferences during office hours to discuss term papers or any other class problems.

Course Objectives: By the end of the semester, the student should be able to:

1. Understand theories of communication - especially interpersonal and small group interaction and problem solving.
2. Analyze the communication problems in intercultural public health situations (roleplaying, etc.)
3. Develop a better understanding of one's own culture and, also of other cultures, understanding the effect of ethnocentrism, plays on perception during intercultural encounters.
4. Understand the effect of roles (within the family structure, etc.) on communication generally (and especially on the public health situations).
5. Understand the influence of intercultural communication on diffusion of an innovation especially within a public health situation.
6. Understand the effect of different languages and verbal symbols on public health and intercultural communication.
7. Apply all of the above communication theories to interpersonal, small group and public health intercultural situations.

Term Project: The purpose of the term project is to demonstrate scholarly research and competence in some area relevant to intercultural communication. The student may elect to either pursue an empirical behavioral science research project or a descriptive paper which synthesizes a body of literature in a particular area.

Field Experience: The field experience requires a brief accounting of an intercultural communication experience. Students are to utilize the criteria they have learned in the course to analyze the significance of and to clarify the experience they had.

INTERCULTURAL COMMUNICATION

ACTIVITY

I. Communication and Intercultural Communication--An Overview

A. Definitions

B. The Communication Process

C. Intercultural Communication Theories

II. Perception

A. Perception--General Orientations

B. Stereotypes

C. Prejudice

D. Ethnocentrism

III. Sociocultural Dimensions

A. Culture

B. Roles

C. Beliefs, Attitudes, and Values

D. Diffusion of Innovations

E. Male-Female Communication (Readings to be assigned)

IV. Verbal Communication

A. Conceptual Orientations

B. Semantics

C. Sapir-Whorf Hypotesis

D. Dialects

E. Language and Racism

F. Argot

V. Nonverbal Communication

A. Definitions

B. Basic Concepts

V. (continued)

C. Intercultural Implications

VI. Intercultural Communicative Competence

A. Definitions

B. Strategies of Competence

C. Project Reports

D. Summary and Review

APPENDIX 2

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Intercultural Communication Bibliography

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International and Intercultural Communication Annual
Journal of Communication, XVI, No. 4, December, 1966. (Entire Issue)
Journal of Conflict Resolution
Journal of Cross Cultural Psychology
Journal of Intercultural Relations
Journal of Teacher Education
Race
Speech Teacher, XIX, March, 1970, No. 2. (Entire Issue)
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APPENDIX 3

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

HEALTH EDUCATION OPTION

BACHELOR OF SCIENCE PROGRAM

The Health Education Option serves those students who are interested in pursuing careers in health education. The program prepares students with skills needed to plan, implement, and evaluate the educational components of health programs. Graduates of the program are employed by official and voluntary health agencies, hospitals, schools, and as professional consultants to various governmental and private organizations. The program meets all Health Science requirements for the Health Science Instruction Specialist Credential and prepares students for entry into the Master's of Public Health degree program in Health Education.

REQUIREMENTS IN THE MAJOR FOR THE B.S. DEGREE:

Lower Division

Biol. 101 General Biology (4)
Biol. 217 or 220 or 225 or 260 (2)
Biol. 218 Human Physiology (3)
Chem. 103 Introductory Chemistry I (3)
H.Sci. 120 Health and Society (2)
Math. 103 Mathematics for Business applications (3)
Psych. 150 Principles of Human Behavior (3)
Socio. 150 Man and Society (3)

Upper Division

Sp.Comm. 356 Intercultural Communications (3)
H.Sci. 390 Biostatistics (4)
H.Sci. 421 Health Behavior (3)
H.Sci. 426 Solving School/Community Health Problems (3)
H.Sci. 432 Source Materials (3)
H.Sci. 435 Health Science for Children and Youth (3)
H.Sci. 437 Strategies for Making Health Decisions (3)
H.Sci. 451 Epidemiology (3)
H.Sci. 470 Community Health Education (3)
H.Sci. 472 Community Health Action (3)

A minimum of 12 units of electives chosen with the prior approval of an advisor. (12)

APPENDIX 4

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

Program for the Master of Public Health Degree
in Health Education

Required Courses

Course Number	Title	Units
H.Sci. 501	Seminar: Research Design	4
H.Sci. 531	Curr. Dev. in Hlth Sci.	3
H.Sci. 533	Communication in Hlth. Ed.	3
H.Sci. 570	Seminar: Current Issues in H.Ed.	3
H.Sci. 571	Adm., Superv., & Consultation in H. Ed.	3
H.Sci. 593A&B	Supervised Field Training	2-2
H.Sci. 597	Directed Comprehensive Studies	
	or	
H.Sci. 598	Thesis/Graduate Project	2

Electives (Select 8 or more units with approval of advisor)

Total Units 30

Professional Preparation of Health Science

at School of Health Sciences, Faculty of Medicine,
The University of Tokyo, Japan
COURSES OF STUDY OF HEALTH SCIENCE (Undergraduate)

Course Requirement(74 units)	unit
Human biology I	16
Human biology II	4
Health Sociology & Psychology	4
Theory of Disease	7
Theory of Environment	6
Health Activities	11
Health Administration	(4)
Health Education	(2)
Maternal & Child Health	(1)
Adult Health	(2)
Mental Health	(2)
Experiment of Health Sciences	6
Seminar: Health Sociology & Psychology	4
Statistics	6
Practice: Human Disease	3
Practice: Health Science	3
Graduate Thesis	4

Electives (over 10 units)	unit
Genetics	1
Medical Chemistry	2
Dietetics	2
Food Hygiene	2
Environmental Physiology	2
Sport Medicine	2
Health Behavior	2
Social Walfare	2
Industrial Health	1
Theory of Disease	3
Nursing	2
Mechanism of Medical Care	2
Radiotherapeutics	2
Environmental Engineering	2
Rehabilitation	1
Practice: Anatomy	1
Practice: Dietetics & Food Hygiene	1
Health Sciences (general)	15-20